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No. 88-1503

In the Supreme Court of the United States

OCTOBER TERM, 1989

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,
Petitioners,

vs.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH and ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,
Respondents,

vs.

THAD C. McCANSE, Guardian ad litem,
Respondent.

ON WRIT OF CERTIORARI TO THE MISSOURI SUPREME COURT

BRIEF OF MISSOURI HOSPITALS, HOSPITAL ETHICS COMMITTEES, MEDICAL SCHOOLS, HOSPITAL CHAPLAINS, HOSPICE ORGANIZATION AND LAW PROFESSORS AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES II
STATEMENT OF INTEREST OF THE *AMICI CURIAE* 1
SUMMARY OF ARGUMENT 8
ARGUMENT 11
CONCLUSION 27
APPENDIX A1

TABLE OF AUTHORITIES

Cases:

Bowen v. American Hospital Association, 476 U.S. 610 (1986) 11
Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) 11
Davis v. Hubbard, 506 F.Supp. 915 (N.D. Ohio 1980) 12
Griswold v. Connecticut, 381 U.S. 479 (1965) 14
Hartke v. McKelway, 707 F.2d 1544 (D.C. Cir.), *cert. denied*, 464 U.S. 983 (1983) 12
In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) 24
In re Farrell, 108 N.J. 335, 529 A.2d 404 (1987) 19
In re Jobes, 108 N.J. 394, 529 A.2d 434 (1987) 14, 17
In re Roe, 383 Mass. 415, 421 N.E.2d 40 (1981) 17
Lambert v. Park, 597 F.2d 236 (10th Cir. 1979) 12
Large v. Superior Court, 148 Ariz. 229, 714 P.2d 399 (1986) (en banc) 12
Lojuk v. Quandt, 706 F.2d 1456 (7th Cir. 1983), *cert. denied*, 474 U.S. 1067 (1986) 13
Meyer v. Nebraska, 262 U.S. 390 (1923) 8, 12
Parham v. J.R., 442 U.S. 584 (1979) 13, 14
Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) (en banc) 9, 21
Skinner v. Oklahoma, 316 U.S. 535 (1942) 12
Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) 15
Thompson v. Oklahoma, 487 U.S. ....., 108 S.Ct. 2687 (1988) 9, 13
Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986) 11

Union Pacific Ry. Co. v. Botsford, 141 U.S. 250 (1891) 8, 11
United States v. Charters, 829 F.2d 479 (4th Cir. 1987), *modified on other grounds*, 863 F.2d 302 (4th Cir. 1988) 8, 12
Youngberg v. Romeo, 457 U.S. 307 (1982) 9, 13

Statutes:

Mo. Rev. Stat. § 334.100.2(4) (1986) 19
Mo. Rev. Stat. § 459.010.3 (1986) 18
Mo. Rev. Stat. § 475.120.2 (1986) 21
Mo. Rev. Stat. § 475.120.3 (1986) 20, 21

Other:

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding To Forego Life-Sustaining Treatment* 75 (1983) 24

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On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF MISSOURI HOSPITALS, HOSPITAL ETHICS COMMITTEES, MEDICAL SCHOOLS, HOSPITAL CHAPLAINS, HOSPICE ORGANIZATION AND LAW PROFESSORS AS AMICI CURIAE IN SUPPORT OF PETITIONERS

STATEMENT OF INTEREST OF THE AMICI CURIAE

This brief is submitted on behalf of Missouri institutions and persons who focus either on health care or the

law.[1] The health care *amici* include Missouri hospitals, hospital ethics committees, medical schools and health care professionals. The law *amici* are comprised of Missouri law professors.

The *amici* represent differing missions and professions. They share, however, the conviction that the court below wrongly decided the petition of Nancy Cruzan's family. The *amici* are convinced that Nancy Cruzan should be allowed to die in accordance with her wishes and with dignity. Further, the *amici* believe the decision of the court below is incompatible with responsible and ethical medical practice. The decision below directly affects the day-to-day practice of many of the *amici* and is of the utmost concern to all who participate in this brief. Consequently, the *amici* urge this Court to reverse the decision of the Missouri Supreme Court.

The health care *amici* include twenty-seven Missouri hospitals or hospital ethics committees. Collectively, the hospitals provide more than 6,900 beds to Missourians in need of care. The participating hospitals are located throughout the state and include urban research and teaching facilities as well as rural regional medical centers. The participating hospitals and hospital ethics committees are:

Audrain Medical Center, Mexico

Barnes Hospital, St. Louis

Bethesda General Hospital, St. Louis

Center for Health Care Ethics of St. Louis University Medical Center, St. Louis

Central Medical Center, St. Louis

1. The parties to this litigation have consented to the filing of this *Amici Curiae* Brief via letters on file with the Clerk.

Dexter Memorial Hospital, Dexter

Heartland Hospital West, St. Joseph

Heartland Hospital East, St. Joseph

Independence Regional Health Center Ethics Committee, Independence

John Fitzgibbon Memorial Hospital, Marshall

Kirksville Osteopathic Medical Center, Kirksville

Lakeside Hospital, Kansas City

Madison Memorial Hospital, Fredericktown

McKune-Brooks Hospital, Carthage

Medical Center of Independence, Inc., Independence

Metropolitan Medical Center, St. Louis

Moberly Regional Medical Center, Moberly

North Kansas City Hospital, North Kansas City

Oak Hill Hospital, Joplin

Ozark Medical Center, West Plains

Perry County Memorial Hospital, Perryville

St. Francis Medical Center, Cape Girardeau

St. Louis Children's Hospital, St. Louis

St. Luke's Hospital, Kansas City

Southeast Missouri Hospital, Cape Girardeau

Springfield Park Central Hospital, Springfield

The Jewish Hospital, St. Louis

Trinity Lutheran Hospital Ethics Committee, Kansas City

The Biomedical Ethics Committee of Hutzel Hospital, Detroit Medical Center, Detroit Michigan, also participates

Two Missouri medical schools—one public and one private—also participate in this brief. The medical schools provide instruction to nearly 1,000 students every year. The participating medical schools are:

The University of Missouri-Columbia School of Medicine, Columbia

The University of Health Sciences College of Osteopathic Medicine, Kansas City

The health care *amici* also include the Missouri Chaplains' Association, a Missouri hospice care group, Hospice Care of the VNA in Kansas City, and Stockhoff Memorial Nursing Home in Fredericktown. These *amici* provide counseling and care to many thousands of Missourians each year. The chaplains work at state hospitals, prisons and mental health institutions as well as at private hospitals. The hospice care personnel offer services ranging from skilled nursing care to death-and-dying counseling to terminally ill persons and their families.

The law *amici* are sixty-four Missouri law professors. The law professor-participants are members of the faculty at Missouri's two public and two private law schools. The law professor-participants are:

Herbert Eastman
Susan FitzGibbon
Barbara Gilchrist
Roger Goldman
Jesse Goldner
Thomas Greaney
John Griesbach
Alan Howard
Sandra H. Johnson
Rochelle Kaskowitz

Terry Lueckenhoff
Josef Rohlik
Peter Salsich, Jr.
Gene Schultz
Eileen Searls
Alan Weinberger
Michael Wolff
Amy Ziegler

All of St. Louis University

Douglas Abrams
Robert Bailey
Susan Csaky
Melody Daily
Peter Davis
Kenneth Dean
David Fisher
Timothy Heinsz
William Henning
Edward Hunvald
Candice Johnson
Nanette Laughrey
Michael Middleton
Leonard Riskin
Richard Tyler
George Wallach

All of the University of Missouri-Columbia

David Achtenberg
William B. Anderson
Mark Berger

Jeffrey Berman
Corinne Cooper
Dennis Corgill
Robert C. Downs
Robert Hayman
Edwin T. Hood
Christopher Hoyt
Patrick D. Kelly
Mary Kay Kisthardt
Nancy Levit
Douglas O. Linder
Joan Mahoney
Robert Popper
John Ragsdale
Pat Randolph
Ellen Suni
G. Ray Warner

All of the University of Missouri-Kansas City

Susan Appleton
Merton Bernstein
M. Susan Carlson
John Drobak
Thomas Glassberg
Michael Greenfield
Laura Mellas
Bernard D. Reams, Jr.
Robin Wellford
Debra Carlson Wood

All of Washington University

The decision of the majority of the Missouri Supreme Court eliminates the ability of families, in consultation with physicians, to order withdrawal of certain medical treatment. The Missouri court did not focus on the fact that medical treatment often is commenced only because there then exists some reasonable hope for the patient's recovery. Under the decision of the Missouri court, treatment must continue even after the hope of recovery or improvement in the patient's condition is foreclosed. This rule applies even though it is subsequently determined that the medical treatment has absolutely no positive effect for the patient.

The *amici* object to the Missouri court's decision to reject a person's right to die with dignity, in favor of an amorphous state interest in continuing life devoid of any emotions, sensory perceptions or other cognitive functions. The *amici* believe that if the decision below is affirmed, families and their physicians may decline to initiate medical treatment where the probability is low that the patient will recover. The *amici* also fear that the decision below may force the initiation of aggressive medical treatment for incapacitated terminally-ill patients, contrary to the patient's expressed wishes. The Missouri court's decision thus makes the patient a prisoner of medical treatment and places an overwhelming burden on the patient's family as they cope with the death of a loved one, artificially extended for an indeterminate time.

The decision below also may restrict the ability of competent persons to declare the medical treatment they desire for the prolongation of their life and the circumstances under which they want nature's course to prevail. The individual's rights to make these decisions are rooted

in our common and constitutional law, yet the majority below appears to have disregarded the importance of the individual's protected rights in favor of a rigid scheme of forced treatment.

The *amici* believe the decision below, if affirmed, would fundamentally alter the traditional practice of providing meaningful medical treatment consistent with the patient's desires. Forcing treatment on a patient who cannot respond is contrary to the tenets subscribed to by the health care *amici*. Removing the input of family members from medical treatment decisions, on behalf of the persons they love and best know, is contrary to the legal and ethical principles held by all the *amici*.

For these reasons, and the reasons stated below, the *amici* urge this Court to reverse the decision of the Missouri Supreme Court.

SUMMARY OF ARGUMENT

I. A. All persons possess the right of self-determination, which includes the right to control over one's own person. *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891). Implicit in this right is the right to choose whether to accept or reject offered medical treatment. The Fourteenth Amendment's protection of traditional liberty interests, *Meyer v. Nebraska*, 262 U.S. 390, 399-401 (1923), grants constitutional protection of this common law right to be free from unwarranted state interference. Lower courts have held this liberty interest to include the right to refuse medical treatment. *United States v. Charters*, 829 F.2d 479, 491 (4th Cir. 1987), *modified on other grounds*, 863 F.2d 302 (4th Cir. 1988).

B. Incompetency does not deprive a person of constitutional rights. *Youngberg v. Romeo*, 457 U.S. 307, 315-16 (1982). The rights of persons unable to exercise choice "are only meaningful as they are exercised by agents acting with the best interests of their principals in mind." *Thompson v. Oklahoma*, 487 U.S. ....., 108 S.Ct. 2687, 2693 n. 23 (1988). Traditionally, family members, as the persons most familiar with the values and beliefs of the incompetent person, have acted as surrogate medical treatment decisionmakers.

II. A. The court below erred in its balancing of the common law and constitutional rights of Nancy Cruzan and the interests of the state. Ms. Cruzan is in a persistent vegetative state (also, "PVS"). The Missouri court reduced her rights by narrowly defining what constituted a burden to her and by ignoring both her previously expressed values and beliefs and whether the medical treatment was of any benefit to her. The Missouri court then excessively elevated the state's interest in life, finding that interest "unqualified", and ignored the state's interest in the integrity of the medical profession, whose stated position supports the decision urged by the petitioners. The result of the court's "balancing" test is predetermined: a person in a PVS must submit to all life-sustaining treatment in furtherance of the state's "unqualified" interest in life.

B. The Missouri court further erred in holding that guardians do not possess the authority to refuse medical treatment on behalf of a ward. The right to consent to medical treatment must include the reciprocal right to refuse. *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674, 688 (1987) (en banc). The lower court's interpretation of a guardian's authority prevents the recognition and exercise of the ward's constitutional rights.

III. The decision of the Missouri court severely distorts the process by which medical treatment decisions will be made in Missouri. If surrogates are denied the right to withdraw medical treatment once a diagnosis of persistent vegetative state is confirmed, they may feel compelled to refuse consent to the initiation of treatment. Further, physicians may be reluctant to recommend the initiation of treatment if their recommendation must include the caveat that the treatment may never be withdrawn.

The decision below may also create the risk that persons in a PVS in Missouri will become the victims of medical technology. Surrogates, physicians or the state may believe that they are now required to provide such persons any and all medical treatment that could further the state's "unqualified" interest in life, regardless of whether the patient benefits from the prolongation of life in a vegetative state.

The Missouri court's decision also has effects beyond those for patients in a PVS. As a result of the decision, it is unclear whether a competent person can effectively declare a refusal of medical treatment, to be effective in the event of future incompetency. The decision also clouds the ability of Missouri guardians to exercise the common law and constitutional rights held by their wards.

ARGUMENT

I. ALL PERSONS HAVE A RIGHT TO ACCEPT OR REJECT MEDICAL TREATMENT.

A. The Right To Accept Or Reject Medical Treatment Arises From The Common Law And Constitutional Law.

This Court has long recognized the common law right of self-determination. In *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891), the Court explained that the right commits to each citizen "the possession and control of his own person." The court found self-determination to be paramount among the people's rights and privileges. *Id.*

The right of self-determination includes each person's right to accept or reject medical treatment. This right has been identified as the source of the doctrine of informed consent:

> The root premise is the concept, fundamental in American jurisprudence, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . ."

Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) *citing Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92, 93 (1914).[2] Implicit in the doctrine of informed consent is the right of each person to balance the benefits and the burdens of offered medical treatment in light of the person's unique

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2. Recent opinions of this Court have also recognized the doctrine of informed consent. *See e.g., Bowen v. American Hospital Association*, 476 U.S. 610 (1986); *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 803 (1986) (White, J. dissenting).

situation. *Hartke v. McKelway,* 707 F.2d 1544, 1548-49 (D.C. Cir.), *cert. denied,* 464 U.S. 983 (1983); *Lambert v. Park,* 597 F.2d 236, 237 n. 1 (10th Cir. 1979).

The patient's right to accept or reject medical treatment also has constitutional foundations. The due process clause of the Fourteenth Amendment serves to protect the liberty interest of citizens from unwarranted interference by the state. *Meyer v. Nebraska,* 262 U.S. 390, 399-401 (1923); *Skinner v. Oklahoma,* 316 U.S. 535, 541-43 (1942). Lower courts have found that the liberty interest protects citizens from state interference in their medical treatment decisions:

> The right to be free of unwanted physical invasions has been recognized as an integral part of the individual's constitutional freedoms, whether termed a liberty interest protected by the Due Process Clause, or an aspect of the right to privacy contained in the notions of personal freedom which underwrote the Bill of Rights. The right to refuse medical treatment has been specifically recognized as a subject of constitutional protection.

United States v. Charters, 829 F.2d 479, 491 (4th Cir. 1987) (footnotes omitted), *modified on other grounds,* 863 F.2d 302 (4th Cir. 1988). *Davis v. Hubbard,* 506 F.Supp. 915, 929 (N.D. Ohio 1980); *Cf. Large v. Superior Court,* 148 Ariz. 229, 714 P.2d 399, 406 (1986) (en banc) (protection guaranteed by liberty interest of state constitution's due process clause).

B. The Right To Accept Or Reject Medical Treatment Extends To Incompetent Persons.

A person's right to accept or reject medical treatment does not hinge on that person's competency or present

ability to exercise the right. Thus, this Court has recognized that an incompetent person, involuntarily committed, retains liberty interests under the due process clause of the Fourteenth Amendment, including the right to be free from bodily restraint. *Youngberg v. Romeo,* 457 U.S. 307, 315-16 (1982). Similarly, this Court has recognized that a retarded child "has a substantial liberty interest in not being confined unnecessarily for medical treatment . . . ." *Parham v. J.R.,* 442 U.S. 584, 600 (1979).

Incompetent persons, however, are by definition incapable of asserting the right to refuse medical treatment.[3] Consequently, an incompetent person's rights should be "exercised by agents acting with the best interests of their principals in mind." *Thompson v. Oklahoma,* 487 U.S. ....., 108 S.Ct. 2687, 2693 n. 23 (1988). This Court's directive in *Thompson* previously was applied in the context of medical treatment decisions:

> [A] patient's incompetency should not deprive him of a liberty interest in "making" treatment decisions. Such a rule would have the absurd result of granting less protection to those incompetent patients who are in greater need of it. It is of course evident that a patient who is by definition incompetent will not really be able to "make" these decisions on his own. But this simply means that someone else acting in the patient's best interests will have to make the decision for him.

Lojuk v. Quandt, 706 F.2d 1456, 1466 (7th Cir. 1983), *cert. denied,* 474 U.S. 1067 (1986).

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3. An exception to this rule exists in the case of advance directives, such as a "living will", executed while the presently incompetent person was competent. No such formalized advance directive is involved in this case.

Medical treatment decisions for incompetent persons usually are made by the closest family member, or a consensus of the close family members. The practice is supported by decisions of this Court recognizing the importance of the family structure in our society. *See e.g., Parham v. J.R.*, 442 U.S. 584, 602 (1979); *Griswold v. Connecticut*, 381 U.S. 479, 496 (1965). The practice has been expressly approved by the New Jersey Supreme Court based on its understanding that family members are most familiar with the values previously expressed by the incompetent person and are most concerned with the best interests of that person:

> Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her. Our common human experience informs us that family members are generally most concerned with the welfare of a patient. It is they who provide for the patient's comfort, care, and best interests, (citations omitted), and they who treat the patient as a person, rather than a symbol of a cause.

In re Jobes, 108 N.J. 394, 529 A.2d 434, 445 (1987) (right of patient in irreversibly vegetative state to determine whether to refuse life-sustaining medical treatment may be exercised by family or close friend).

The designation of a surrogate decisionmaker may occur informally, on the basis of the health care professionals' knowledge of the family structure, or formally through a guardianship appointment. Whether designated formally or informally, the surrogate decisionmaker determines whether to accept or reject medical treatment

under the substituted judgment doctrine. The goal of this doctrine is that:

> the decision . . . should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.

Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417, 431 (1977).

The courts have recognized for many years the individual's right to reject medical treatment. That right extends to incompetent persons and traditionally is exercised for the incompetent person by close family members. The Missouri Supreme Court ignored these constitutional rights and traditional values. As a result, it erred in rejecting the Cruzan family's request to exercise their daughter's right to be free of unwanted medical treatment.

II. THE DECISION BELOW VIOLATES NANCY CRUZAN'S COMMON LAW AND CONSTITUTIONAL RIGHT TO REJECT MEDICAL TREATMENT.

A. Nancy Cruzan's Right To Refuse Medical Treatment Includes The Right To Have A Decision Made By Her Family.

Nancy Cruzan is in a persistent vegetative state (also, "PVS") from which she has no hope of recovery. Through her partially functioning brain stem, she is able to breathe without assistance, but she has lost the abil-

ity to swallow food or water. She is totally and permanently unconscious and has lost all capacity for thought and sensation.

Nancy Cruzan is absolutely powerless to assert any control over her own medical treatment. Her inability to assert control, however, does not strip her of the right to accept or reject medical treatment. Nancy retains the right to medical treatment decisions consistent with her values and beliefs; only the method by which the right is exercised changes. Joe and Joyce Cruzan, as Nancy's parents, are the persons best able to assert her right to accept or refuse medical treatment.

The court below held "that the co-guardians do not have authority to order the withdrawal of hydration and nutrition to Nancy." *Cruzan*, Pet. App. at A42. In so holding, the Missouri Supreme Court has deprived Nancy Cruzan of the right to have her medical treatment decisions made by those persons most familiar with her value system and most concerned about her best interest.

In reaching its conclusion, the Missouri court purported to construct a "balancing" test, weighing the burdens from continued treatment against the state's interest in continued life. In fact, the court engaged in no meaningful examination of what it viewed to be competing interests of Nancy and the state.

In analyzing the Cruzan family's request, the Missouri court held that "we do not believe the care provided by artificial hydration and nutrition is oppressively burdensome *to Nancy* in this case." *Cruzan*, Pet. App. at A37 (emphasis in original). Thus, the Missouri court ruled that the only issue on Nancy's side of the balance

is whether the continued nutrition and hydration is painful to her. Since, by definition, persons in a PVS can not experience pain, no medical treatment could ever be found to be "oppressively burdensome" to them.

The Missouri court ignored many factors which should have entered Nancy's side of the balance. Certainly patients, or their surrogates, facing important medical treatment decisions focus on the efficacy of proposed treatment, the post-treatment effect on their body and spirit and the burdens which the proposed treatment will place on their family.[5] These factors are considered in connection with the likelihood that the patient will appreciate some benefit from the treatment. The Missouri court, however, could not identify any benefit the continuation of medical treatment can have for a person who has existed in a persistent vegetative state for over six years. In fact, the court admitted that "the evidence is clear and convincing that Nancy will never interact meaningfully with her environment again." *Cruzan*, Pet. App. at A34.

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5. Other state courts have recognized that a surrogate decisionmaker "might consider the patient's likely attitude toward the impact of his or her choice of medical treatment on his or her loved ones . . . ." *In re Jobes*, 108 N.J. 394, 529 A.2d 434, 444 n. 10 (1987); *see, In re Roe*, 383 Mass. 415, 446, 421 N.E.2d 40, 58 (1981):

> An individual who is part of a closely knit family would doubtless take into account the impact his acceptance or refusal of treatment would likely have on his family. Such a factor is likewise to be considered in determining the probable wishes of one who is incapable of formulating or expressing them himself. In any choice between proposed treatments which entail grossly different expenditures of time or money by the incompetent's family, it would be appropriate to consider whether a factor in the incompetent's decision would have been the desire to minimize the burden on his family.

The Missouri court "balanced" the other side of its scale only with the state interest in preserving life. *Cruzan*, Pet. App. at A25. The court found this interest to be "unqualified". *Cruzan*, Pet. App. at A33.[6] Given the lower court's narrow view of what can be a burden to Nancy and its expansive view of the state's interest in the preservation of life, the outcome of the "balancing test" is predetermined: a patient in a persistent vegetative state must submit to the continuation of all life-sustaining medical treatment. The court incorrectly found that the state's interest in life is "unqualified," and then relied on that finding as justification for usurping the traditional approach taken by physicians and patients, or patients' surrogates, in making medical treatment decisions.[7]

In identifying an exclusive state interest, the Missouri court found unimportant the state's interest in the integrity of the medical profession. This is contrary to the

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6. The majority's conclusion of the state's "unqualified" interest in life was challenged by a dissenting justice of the Missouri Supreme Court:

> The very existence of capital punishment demonstrates a relativity of values by establishing the proposition that some lives are not worth preserving. Furthermore, the "Living Will" statute, which the majority finds to be "an expression of the policy of this state with regard to sanctity of life," in fact allows and encourages the pre-planned termination of life. .

Cruzan, Pet. App. at A49 (Blackmar, J., dissenting).

7. In reaching its conclusion regarding the state's "unqualified" interest in life, the Missouri court considered as relevant evidence, part of the Missouri "Living Will" statute. The court focused on the statute's exemption of "any procedure to provide nutrition or hydration" from those death-prolonging medical procedures which a competent person may refuse in the event of future incompetency. Mo. Rev. Stat. § 459.010.3 (1986). *Cruzan*, Pet. App. at A29. The court's focus was improper because the statute's exemption violates the common law and constitutional right of competent persons to exercise choice concerning future medical treatment decisions.

express findings of the New Jersey Supreme Court. *In re Farrell*, 108 N.J. 335, 529 A.2d 404, 410-11 (1987) (right to refuse medical treatment must be balanced with the state's interest in the preservation of life, the prevention of suicide, the protection of innocent third parties, and the integrity of the medical profession). Further, the Missouri court's view is inconsistent with the Missouri statute authorizing revocation of a physician's license for "unethical conduct," Mo. Rev. Stat. § 334.100.2(4) (1986).

The Missouri court's disregard of the state's interest in ethical medical practice has been criticized by the Missouri State Medical Association ("MSMA"). The MSMA believes the decision below is irreconcilable with conduct which its members believe to be appropriate. On April 15, 1989, the MSMA adopted a resolution titled "Right to Forego Life Support" (Appendix A). The resolution states, in part:

> [T]he decision to withdraw artificial hydration and/or nutrition (tube feeding) from terminally ill or irreversibly comatose patients should be allowed when directed by the patient, family, medical proxy, or by prior "Living Will" declaration of the patient; . . .
>
> RESOLVED, that ethical decisions such as the right to refuse treatment be left to the individual, family and/or Health Care Surrogate, and not to the state.

The members of the MSMA also adhere to all opinions issued by the American Medical Association's Ethical and Judicial Counsel, including AMA Statement 2.18, issued in 1986. The AMA Statement acknowledges that

> Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis

and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment.

It is clear that recognition of Nancy Cruzan's right to refuse medical treatment is consistent with the ethical positions adopted by Missouri physicians. The Missouri court's decision to force treatment on Nancy, or any other person in a PVS, compromises these positions and compels Missouri physicians to violate their own tenets regarding ethical practice.

Nancy Cruzan has a right to refuse medical treatment and that right may be exercised by her family, guided by Nancy's values and beliefs. Although Nancy's right is not absolute and may be balanced against recognized state interests, the Missouri court seriously erred in its balancing. The court erred by discounting an incompetent person's common law and constitutional right to refuse medical treatment, by excessively elevating the state interest in life and by ignoring the ethical integrity of the medical profession. Had the Missouri court properly weighed the individual rights and state interests, it would have found the balance to be in Nancy's favor.

B. Nancy Cruzan's Right To Refuse Medical Treatment Is Not Altered By The Appointment Of Her Parents As Co-Guardians.

The Missouri court disposed of the Cruzan family's request to terminate Nancy's medical treatment by reference to a portion of the Missouri guardianship statute, Mo. Rev. Stat. § 475.120.3 (1986). The court stated that "[t]he statute makes no provision for the termination of medical treatment." *Cruzan*, Pet. App. at A39.

The Missouri court ignored, however, the section of the guardianship statute providing that "[a] guardian or limited guardian of an incapacitated person shall act in the best interest of the ward." Mo. Rev. Stat. § 475.120.2 (1986). Implicit in this charge is the principle that the guardian must have discretion to choose, among the available alternatives, that option which the guardian believes to be in the ward's best interest. Among those options is the option to decline medical treatment.

Furthermore, the Missouri court essentially ruled that the guardian may not exercise any judgment in performing the statutory duties to "[a]ssure that the ward receives medical care" and to "provide required consents on behalf of the ward". Mo. Rev. Stat. § 475.120.3 (1986). The Missouri court's interpretation turns guardians into mere state functionaries, obligated to seek out all medical care which could possibly serve to further the state's "unqualified" interest in life, regardless of the impact on the ward.[8]

The Missouri court's decision also is in conflict with standard principles and practices of obtaining informed consent to medical treatment. The right to consent to

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8. The Arizona Supreme Court, addressing the issue of whether a guardian's right to consent to treatment on behalf of a ward included the right to refuse or withdraw treatment, held:

> In our opinion, the right to consent or approve the delivery of medical care must necessarily include the right to consent to or approve the delivery of *no* medical care. To hold otherwise would, as the Washington and Minnesota supreme courts observed, ignore the fact that oftentimes a patient's interests are best served when medical treatment is withheld or withdrawn.

Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674, 688 (1987) (en banc). The court found that the guardian "had the implied, if not express, statutory authority to exercise [the ward's] right to refuse medical treatment." *Id.*

medical treatment must, by necessity, confer the reciprocal right to refuse medical treatment. This right to refuse is not forfeited by the guardianship process. It may be asserted by the guardian, on behalf of the ward, either when the treatment is first proposed or after treatment has been initiated if it becomes apparent that continuation of the treatment is not in the ward's best interest.

In support of its opinion that the guardianship statute confers no right to refuse or withdraw medical treatment, the Missouri court considered the source of the guardian's authority to decide. The court found that:

> "[a] guardian's power to exercise third party choice arises from the state's authority, not the constitutional rights of the ward. The guardian is the delegatee of the state's *parens patriae* power.

Cruzan, Pet. App. at A41 *citing In re Link*, 713 S.W.2d 487, 493 (Mo. 1986) (en banc). This interpretation of a guardian's role serves to defeat the very essence of the guardianship process: to ensure that decisions are made in the *ward's* best interest. Taken to its logical conclusion, a guardian in Missouri now is required to act in the *state's* best interest, ignoring the common law and constitutional rights of the ward whenever there is a conflict between the best interest of the ward and the state's "unqualified" interest in life. Such results clearly violate the constitutional rights of the ward and are not permissible.

The function of the surrogate medical decisionmaker, whether informally designated or formally appointed under a guardianship statute, is to make certain that the rights and best interests of the incapacitated person

are protected. Whether such protection is accomplished by accepting or rejecting specific medical treatment is a situation-dependent determination. The type and amount of information available to the surrogate decisionmakers will differ with each incompetent person for whom decisions must be made - from specific statements concerning the desire not to be maintained on specific types of artificial life-sustaining treatment when no chance of recovery remains, to general statements concerning attitudes toward life and death. The determination is best made by family members or friends in closest contact with the incapacitated person, in consultation with the physicians responsible for that person's care.

III. THE DECISION BELOW SEVERELY DISTORTS MEDICAL TREATMENT DECISIONS IN MISSOURI.

The Missouri court severely distorted the process of making medical treatment decisions in Missouri. Given the uncontroverted fact that a person in a PVS cannot experience pain and therefore cannot be "burdened" as that term is defined by the majority below, there is nothing to be "balanced" on behalf of such person against the state's interest in life. The decision below essentially requires that a person in a persistent vegetative state submit to the continuation, and perhaps even the institution, of all medical treatment that could be classified as life-sustaining, in furtherance of the state's interest in life.

The adverse consequences of the Missouri court's decision in this case are significant and varied. In fact, the opinion may serve to accomplish the exact opposite of its purported goal: fear of not being able to withdraw life-sustaining treatment may lead physicians and family mem-

bers to err on the side of not treating an incapacitated patient when the chances for recovery are uncertain. This danger was recognized by a court presented with a guardian's request to remove a gastrostomy tube on behalf of a comatose patient:

> Moreover, from a policy standpoint, it might well be unwise to forbid persons from discontinuing a treatment under circumstances in which the treatment could permissibly be withheld. Such a rule could discourage families and doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die.

In re Conroy, 98 N.J. 321, 486 A.2d 1209, 1234 (1985). *See also*, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding To Forego Life-Sustaining Treatment* 75 (1983), ("An even more troubling wrong occurs when a treatment that might save life or improve health is not started because the health care personnel are afraid that they will find it very difficult to stop the treatment if, as is fairly likely, it proves to be of little benefit and greatly burdens the patient.").

Decisions of whether to institute, continue or withdraw a given medical treatment should be made on the basis of the best information currently available to the physician and the surrogate decisionmakers. As the incompetent person's condition changes, or more information concerning his or her condition becomes available, the appropriateness of particular medical treatment will change. Physicians and surrogate decisionmakers should not be forced to consider, as one of the risks of instituting medical treatment, the risk of never being allowed to withdraw

that treatment. The right to consent to treatment on behalf of an incompetent person must contain the right to withdraw the treatment when to do so serves the best interests of that person.

The decision below also creates the risk that a person in a PVS will become the prisoner of medical technology. The Missouri court's ruling may require that persons in a persistent vegetative state receive all medical treatment that could in any way further the state's interest in that person's life. Since the person will not be "burdened" by the treatment, the state's interest in life will always tip the scale in favor of treatment.

Although the majority below purports to limit its holding to the narrow facts presented,[9] the opinion has effects reaching far beyond those for patients in a PVS. The Missouri court's finding that the state's interest in life is "unqualified" has implications for competent persons attempting to exercise the right to refuse life-sustaining medical treatment - either directly while competent or through an advance directive to be used in the event of incompetency. Under the court's "balancing test", it is unclear whether even a competent person's effort to exercise the right to refuse medical treatment could outweigh the state's interest in preservation of life.

The opinion also has significant effects on the ability of guardians to exercise rights of wards who are not in a PVS. Under the Missouri court's interpretation, a guardian's role in medical treatment decisionmaking is limited to assuring that the ward receives medical care and to

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9. The majority stated that "[a] single issue is presented: May a guardian order that all nutrition and hydration be withheld from an incompetent ward who is in a persistent vegetative state, who is neither dead within the meaning of Section 194.005, RSMo 1986, nor terminally ill?" *Cruzan*, Pet App. at A6.

providing all required consents. The guardian has no discretion to refuse any care on behalf of the ward, and arguably, will now be required to obtain and consent to all medical care which has the slightest chance of prolonging the ward's life without causing pain. The court's finding that the guardian's power arises from the state's authority, and not the constitutional rights of the ward, essentially deprives all wards in Missouri of the exercise of all constitutional rights.

Decisions concerning whether to initiate, continue or withdraw life-sustaining medical treatment on behalf of an incompetent person are extremely complex and personal. They require the consideration of a multiplicity of factors, ranging from the incompetent patient's medical condition to his or her value system. These decisions have traditionally been made by the patient's family in conjunction with the advice and information provided by the treating physicians and, if available, the hospital ethics committee. Incompetent patients have common law and constitutional rights in this decision-making process. Those rights may not be violated by state courts' or legislatures' attempt to draw bright-line rules.

CONCLUSION

For the foregoing reasons, and those stated in the briefs of petitioners and other *amici*, the judgment of the Missouri Supreme Court should be reversed.

Respectfully submitted,

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September 1, 1989

APPENDIX

MISSOURI STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

Resolution #14
(A-89)

Introduced by:

Cape Girardeau County Area Medical Society

Subject:

Right to Forego Life Support

Referred to:

Reference Committee on Constitution and Bylaws

WHEREAS, the decision to withdraw *artificial* hydration and/or nutrition (*tube feeding*) from terminally ill or *irreversibly* comatose patients *should be allowed when directed by the patient, family, medical proxy, or by* prior *"Living Will"* declaration of the patient; and

WHEREAS, Section 459.010(*3*) of the "Missouri Declaration on Life Support (Living Will)" prohibits withdrawal of artificial nutrition/hydration and is clearly an infringement upon the rights of the individual by the State of Missouri; and

WHEREAS, many states along with the President's Commission on Biomedical Ethics (1983) have favored "Health Care Surrogate" legislation over "Living Will" laws (459.010-459.030) to preserve patients' right of self-determination when decision making capacity is lost; therefore, be it

RESOLVED, that the Missouri State Medical Association calls upon the Legislature of the State of Missouri to delete *the phrase in* section 459.010*(3)* of the "Missouri Declaration on Life Support" which defines providing *artificial* hydration or nutrition *(tube feeding)* as "not being a death-prolonging procedure"; and be it further

RESOLVED, that the Missouri State Medical Association supports additional legislation which affirms the rights of Missouri citizens to appoint a "Health Care Surrogate". This individual(s) could be chosen by a competent patient to act as his/her medical proxy making health care decisions when patient decision making capacity is lost. Such duly appointed medical proxies should have power to approve or refuse any and all medical treatment, including food and water provided by artificial means (tube feeding), when the burdens of such treatment outweigh the benefits and/or such treatment would violate the wishes of the patient as known by the proxy. Missouri physicians therefore support prompt legislative approval of a Health Care Surrogacy Act or its equivalent to help insure our citizens' right of self-determination; and be it further

RESOLVED, upon passage of satisfactory health care surrogate legislation and deletion of the restrictive phrase in Section 459.010(3), MSMA will support and publicize the value of such legislative changes to Missouri citizens and to physicians and health related professions; and be it further

RESOLVED, that ethical decisions *such as the right to refuse treatment* be left to the individual, *family and/or Health Care Surrogate, and* not to the State.